**Texas Department of Insurance**
*Division of Workers' Compensation*
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name**
Whitestone Physical Therapy

**Respondent Name**
Service Lloyds Insurance Co

**MFDR Tracking Number**
M4-15-0710-01

**Carrier's Austin Representative**
Box Number 01

**MFDR Date Received**
October 22, 2014

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "I believe that these claim need to be paid by the employer as I was originally informed that all his claims would be honored. These clams were submitted in a timely fashion to Donna Krall as evidenced by the fact she had them on her computer in July when I spoke with her. "

**Amount in Dispute:** $138.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Respondent respectfully submits that HCP failed to obtain required preauthorization per 28 TAC Chapter 134, failed to submit a complete bill timely for indicated dates of service, and failed to submit a request for reconsideration per 28 TAC Chapter 133 and maintains that their denial was appropriate and correct."

**Response Submitted by:** CorVel Corporation

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| November 5, 2013 | 97010, 97110 | $138.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out guidelines for prospective and concurrent review of health care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Payment adjusted for absence of precert/preauth
   - 18 – Duplicate claim/service

**Issues**

1. Was the denial of the services in dispute supported by the Carrier?
2. Is the requestor entitled to reimbursement?

**Findings**

1. The carrier denied the disputed service as 197 – "Payment adjusted for absence of precert/preauth." 28 Texas Labor Code §134.600 (c) states, "The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);(B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;" and (p) states, "Non-emergency health care requiring preauthorization includes:(5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to: (i) Modalities, both supervised and constant attendance; (ii) Therapeutic procedures, excluding work hardening and work conditioning;" Review of the submitted documentation finds no prior authorization was sought or obtained for the services in dispute. Therefore the Carrier's denial is supported.
2. As the applicable Division rules pertaining to prior authorization were not met, no additional payment can be recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | April 23, 2015<br>Date |
|---|---|---|

***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.